(7.)

SYLLABUS OF LECTURES

ON

MIDWIFERY,

AND THE

DISEASES OF WOMEN AND CHILDREN.

BY

G. OAKLEY HEMING, M.D., F.L.S.

PHYSICIAN-ACCOUCHEUR TO THE ST. PANCRAS INFIRMARY;
LECTURER ON MIDWIFERY, ETC., ETC.

LONDON:

WM. DAVY, PRINTER, GILBERT-STREET, OXFORD-ST[illegible]

SYLLABUS.

PELVIS—peculiar to vertebrated animals—distinctions between the pelvis of man and of animals—consists of a greater number of bones in the young subject than in the adult—advantages of this at the time of birth—not completely developed or fit for the functions of parturition till the age of puberty.

ADULT PELVIS—practical remarks on the bones separately—sacrum—ossa innominata—os coccygis—familiar terms by which these bones are designated.

Mode of union—number of articulations, five; 1. the sacro-lumbar—ligament—sacro-vertebral angle. 2. Sacro-coccygeal articulation—ligaments—lateral motion restrained—motion backwards, free—more extensive in the female than in the male—the bones sometimes anchylosed—occasionally fractured during labour, and dislocated from accidents—inflammation of, from laborious labour—diagnosis—treatment. 3. Sacro-iliac symphysis, right and left—great strength given to this articulation by the wedge-like form and bevelled edges of the sacrum—division of articulating surfaces into two—proper ligaments—anterior stronger and thicker than posterior—additional strength afforded by sacro-ischiatic ligaments—relaxation of this articulation—symptoms—treatment. 4. Symphysis Pubis—Dr. William Hunter's description—Velpeau's—separation of the bones a natural process at the time of labour (?); observations of Dr. William Hunter—Baudelocque—Dewees—my own examinations;—separation takes place naturally in some animals—but in the human subject is always a morbid condition; causes—symptoms—treatment—important, in the diagnosis and treatment of inflammation of this articulation, to recollect the comparative thinness of the ligaments at the posterior part compared with those at the anterior.

PELVIS COLLECTIVELY — form — distinction between the male and female pelvis—division into 1, the false, and 2, the true pelvis—use, measurement, boundaries of the former;—true pelvis—depth at various parts—a curved canal —inclination of the pelvis upon the spine—inlet or brim; plane of the brim forms an obtuse angle with the vertebral column—form of the brim—diameters—axis. Cavity—form of; lateral inclined planes—outlet—form—diameters—axis —a knowledge of these absolutely necessary to the accoucheur—observations on the introductions of the forceps.

SOFT PARTS CONNECTED WITH THE INTERIOR AND APERTURES OF THE PELVIS—description alone inadequate —1, at the brim—psoæ, and large blood-vessels;—diminish the extent of its transverse diameter;—2, in its cavity—pyriformis, obturator internus, pelvic fascia;—3, the parts closing the outlet consist of two layers, the upper convex, the lower concave.

FŒTAL SKULL — form — sutures — fontanelles — diameters.

DEFORMITY OF THE PELVIS—usually takes place at the brim, and in the direction of the conjugate diameter—may be confined to one side only—important to know whether both the brim and outlet be affected, or only one of these—how to ascertain defective proportions in the living subject—means of ascertaining the extent of the conjugate diameter—various instruments—that of Aitkin, Coutouli, Baudelocque; —how to measure the transverse and oblique diameters at the brim, and the long and short diameters at the outlet. Rickets—the most frequent cause—this disease first described by Glisson;—a disease of infancy—owing to the want of the due secretion of phosphate of lime;—Dr. Davy's opinion—curable—symptoms—treatment. Mollites ossium—sometimes the cause of the worst forms of deformity—caused by absorption of phosphate of lime;—a disease of adult age—generally makes its attacks after child-bearing—incurable; symptoms—this deformity is said to be different from that produced by rickets. Dr. Hull's opinion—in rickets, the first labour is as difficult as subsequent ones—the reverse is observed in Mollites ossium—this an important fact as re-

gards the induction of premature labour—fracture sometimes the cause of distortion ;—exostosis sometimes, but very rarely, the cause of distortion.

Pelvis sometimes unusually large—consequences—sometimes unnaturally small, without deformity.

Pelvic Viscera—relative situation—the uterus—form and size—external surface—how covered by the peritonæum ;—internal surface—question as to its being lined by a mucous membrane—circumstances in favour of this opinion ; parenchyma or proper tissue of the uterus—proof of its muscularity—direction of its fibres—the opinions of Hunter, Sir C. Bell, and Madame Boivin ;—blood-vessels—nerves—lymphatics;—ligaments—broad—round ; Fallopian tubes—structure—opening into the peritoneal sac. Ovaries—situation—attachment—the proper tunic—a continuation of the ligament—peritoneal covering ; Vesicles of De Graafe—Baer's discovery.

The Uterine Organs — one function periodical — inert before the age of puberty — changes dependent upon the proper development of sexual organs—cases in support of this opinion—Pear's, Pott's, &c.—period at which the catamenia usually occur—modified by various circumstances—not sudden, but preceded by certain symptoms—period of life during which this function is performed—interrupted by pregnancy, and generally by nursing—duration of each period—interval between the periods—nature of the discharge—in disordered conditions of the constitution sometimes colourless—part of the sexual organs from which it is secreted—quantity varies in different individuals—various opinions of authors as to its efficient cause—as to its final cause—cessation.

Conception—power of reproduction peculiar to organized beings—modes of reproduction in the lower classes of animals — this function more and more complicated in the higher animals;—various modes of reproduction—various hypotheses relative to impregnation in the higher classes ; discovery of animalculæ in the semen by Ham, and communicated by him to Leewenhoeck—confirmed recently by

Prevost and Dumas;—De Graafe's experiments—repeated by Dr. William Hunter. Does the male semen obtain contact with the ovula of the female? if, so, where?—the experiments of Spalanzani—of Haighton—Blundell—Nuck—and of Prevost and Dumas—Ruysch's case.

The Gravid Uterus—first, changes in consequence of impregnation—observed in the ovary—changes occurring in the Graafian vesicle itself, 1, before the escape of the germ; —2, after;—corpus luteum—characteristics of the true corpus luteum in the human subject—importance of becoming well acquainted with this subject—case of Miss Burns—true corpus luteum *always* the result of conception—to be distinguished from the yellow bodies sometimes found in the ovaries of virgin animals—supposed function of the corpus luteum—Valentine's opinion—superfœtation. Changes occurring in the uterus itself—1, relative to size—not enlarged by distention—enlarges more at the posterior than the anterior part;—2, alteration of texture;—3, alteration of form at different periods;—4, changes in the cervix;—5, changes of position—1, at the early period of pregnancy—2, at the latter period. Changes occurring within the cavity of the uterus—1, Deciduous membrane—Dr. Hunter's description;—perforations (?)—opinions of British and foreign authors; 1, decidua vera—2, decidua reflexa—explanation of its formation;—at what period the ovum enters the uterus after impregnation (?)—cases of Sir E. Home, Mr. Ogle, M. Velpeau; 3, chorion—description—source—various opinions;—4, amnion—description—relation to the chorion—structure—liquor amnii—composition—various opinions as to its use;—5, vesicula umbilicalis—situation—form—contents—duct—blood-vessels—progressive changes;—M. Velpeau's opinion as to its use;—6, placenta—size—shape—opinion of authors as to its structure—Mr. Hunter's—whether divided into fœtal and maternal portions—of what nature is the membrane interposed between it and the uterus—whether any large blood-vessels pass from the uterus—whether any direct communication between the blood of the fœtus and that of the mother. Umbilical cord—structure—length—point of

insertion into the placenta—blood-vessels, one artery and two veins—communicate frequently with each other in cases of double placenta—peculiarities of their distribution.

Anatomical peculiarities of the Fœtus—of its hepatic, its respiratory, and its circulatory systems.

ABORTION.

If the ovum be expelled before the sixth month from the time of conception, the process is called abortion—if after, premature labour;—practical utility of this distinction—division of abortion into three classes:

1. From premature action of the *Uterus*—
    1. From natural disposition;
    2. From irritation of the Rectum;
    3. From diseases of the Uterus itself, or of the adjacent organs.
2. From premature detachment of the *Ovum*—
    1. From accidents, blows, falls, injuries;
    2. From violent coughing, straining, &c.
3. From the death of the *Fœtus*—
    1. From disease of the Fœtus;
    2. From disease of other parts of the Ovum;
    3. From diseases of the Mother.

Symptoms peculiar to each class. In forming our prognosis, two points to be considered—the danger to the fœtus—the danger to the mother. It has been erroneously supposed by a distinguished writer, that when the uterus has once begun to contract, it necessarily continues to do so till abortion takes place. Generally supposed, that, where hæmorrhagy is accompanied by intermittent pains, abortion inevitably occurs;—some exceptions to this:—danger in great measure proportionate to the advancement of gestation;—in the prognosis, the cause upon which the threatened abortion depends, to be considered. Treatment consists—1. in attempts to prevent it;—2. in endeavours to conduct the

patient safely through it, supposing it inevitable. Consideration of

1. The principal prophylactic measures ;
2. The chief remedies to be used when the process has already begun ;

1. to remove the *cause;*—2. to lessen or remove *pain;* 3. to moderate or check *hæmorrhagy;*—use of the *tampon.* Question as to the promotion of the expulsion of the ovum.—means—1. the *Secale Cornutum;*—2. puncturing the membrane ;—3. manual or instrumental assistance.

DIAGNOSIS OF PREGNANCY.

The diagnosis of Pregnancy extremely important—presents no difficulty in ordinary cases, but is occasionally exceedingly obscure — pregnancy sometimes mistaken for disease, and the reverse—symptoms of pregnancy :

1. Cessation of the catamenia — women have become pregnant before the appearance of the catamenia—Sir E. Home's case—sometimes become pregnant during the absence of the catamenia, whilst nursing—Wenzel's remark—catamenia often cease from disease—observation as regards this circumstance in consumption, by M. Louis. Do the the catamenia ever continue during pregnancy ?—examination of cases brought forward in support of this opinion—Daventer's, Dewee's, Velpeau's, Montgomery's ;—may occur in case of double uterus.

2. Morning sickness.

3. Alterations in the mammæ—Dr. Montgomery's remarks as regards the changes in the areola—fluid sometimes in the mammæ without pregnancy—a peculiar mottled appearance sometimes occurring during pregnancy, first described by Mr. Ingleby, depicted by Dr. Montgomery.

4. Swelling of the abdomen—two classes of patients liable to be deceived by this symptom—1. the newly married —2. those in whom the catamenia are about to cease.

5. Tumour at the lowest part of the abdomen gradually rising higher—various causes giving rise to such a circumstance—how distinguished from pregnancy.

6. Quickening—most usual period—opinion of women on this point—cases in which it has occurred very early and very late.

7. Alterations in the cervix uteri.

8. Ballottement, or repercussion of the fœtus—1. vaginal; —2. hypogastric.

9. Motion of the child felt by the accoucheur.

10. Changes in the umbilicus.

11. Evidence obtained by the stethoscope, first employed by Mayor of Geneva and M. Kergaradec—two distinct sounds —1. placental souffle synchronous with the pulse of the mother—always heard in the same situation—first heard after the *fourth* month. 2. Sounds of the fœtal heart—these do not correspond with the pulse of the mother—they consist, not as has been generally supposed, in 120 double beats, but in half that number, producing 120 *sounds;* (the pulse of the fœtus is slow, or 60, *before*, and double that number, or 120, *after* respiration—remark of Smellie)—*this* sound first heard after the *fifth* month. In forming our diagnosis, little reliance must be placed on the symptoms individually; they must be considered in the *aggregate*, and in reference to the various *periods* of pregnancy.

CLASSIFICATION OF LABOURS.

The various kinds of labours may be divided into four Classes:—

I. Natural Labour:

II. Impeded Labour,
   I. From want of power;
   II. From the disproportionate size, or mal-position of the child's head.
   III. From diminution of the passage through which the child has to pass.

III. Preternatural Labour:
   I. *Requiring turning*, comprehending the presentation of the umbilicus, and all the parts *above* it.

II. Where *turning* is *unnecessary*, comprehending the presentation of all the parts situated *below* the umbilicus.

IV. Complicated Labour:

I. Twins, Triplets, &c.
II. Puerperal convulsions;
III. Uterine hæmorrhagy before the birth of the child;
IV. Rupture of the Uterus;
V. Inversion of the Uterus.

CLASS I.—NATURAL LABOUR.

The duration of human pregnancy about nine calendar months, or, more accurately, 40 weeks, or 280 days—error on this point—various opinions as regards the duration of human pregnancy—discrepancy of medical evidence in the Gardiner peerage case—mode of calculating the period at which a pregnant woman will probably be confined.

Diagnosis of *labour*:—important to decide at once whether the patient be actually in labour or not. The *toucher*—mode of performing it—false pains—how distinguished from labour-pains—os uteri frequently dilated to the size of a sixpence, or more, a fortnight before labour—a fact known to Mauriceau—treatment of "false pains."

Division of labour into three stages:

1. Dilatation of the os uteri and rupture of the membranes;
2. Descent of the child; dilatation of the external parts; expulsion of the child;
3. Separation of the placenta; the expulsion or extraction of the placenta; due contraction of the uterus.

Description of each of these;—duties of the accoucheur:

1. To support the perineum;
2. To divide the funis;
3. To remove the placenta.

How and when to divide the funis—use of a second ligature—when and how to remove the placenta—different opinions upon this subject.

Of HEMORRHAGY: this occurs—1, sometimes after the birth of the child;—2, sometimes after the expulsion of the placenta;—it is divided into external and internal—symptoms of internal hemorrhagy—various conditions of the uterus and of the placenta in internal hemorrhagy:

1. Inertia of the uterus.
2. Hour-glass contraction.
3. Partial adhesion of the placenta.
4. Placenta detached, but not expelled.

Mode by which hemorrhagy is moderated, or arrested naturally—treatment founded upon a knowledge of this. The object to produce contraction of the uterus—1, by pressure, internal and external;—2, by the external application of cold. Other remedies which have been recommended in uterine hemorrhagy—1, the tampon;—2, pressure upon the aorta;—3, the ergot of rye. Various opinions as to the propriety of introducing the hand into the uterus when hemorrhagy occurs after the expulsion of the placenta.—Important question as to the exhibition of stimulants when syncopy occurs as the consequence of hemorrhagy.

Dr. Gooch's description of uterine hemorrhagy—cause, prevention, and treatment.

Intra-vaginal hemorrhagy—first described by myself—noticed afterwards by M. Velpeau—symptoms—attended by intermittent pain—treatment.

Of the treatment of the effects of hemorrhagy — of transfusion, &c.

RETENTION OF THE PLACENTA WITHOUT HEMORRHAGY—causes—how long to wait—treatment.

CLASS II.—IMPEDED LABOURS.

Divided into—First order:—those dependent on want of power—1, constitutional causes,—febrile state — natural

weakness—delicacy of constitution—debility from disease ;—2, local causes—various diseases,—mal-position,—over-distention,—irregular contraction of the uterus ;—diagnosis—treatment.

Second order :—from increased bulk or mal-position of the child's head—1, child proportionate, but much larger than common ; 2, child's head disproportionately large from disease, as hydrocephalus—how known—treatment ;—3, impediment from wrong position of the child's head—knowledge of the mechanism of parturition necessary to a successful practice—situation of the head at the beginning of labour—theory of authors at an early period—that of Sir F. Ould, Smellie—opinions at the present time—indebted to Solares for a correct description of the situation of the child's head at the commencement of labour—head said to be situated in six different positions, two of which so rarely occur that they have been denied by some authors. First position—description of—mechanism of. Second position—rarely occurs—how distinguished—mechanism—does not retard labour. Third position—how distinguished—mechanism—important to distinguish this position early—treatment—Dr. Clarke's cases—oblique forceps seldom necessary—turning, if detected early—Dr. Blundell's opinion. Fourth position—Baudelocque's description—Naegelé's.

Presentations of the face—four kinds mentioned by authors ; two of which rarely, if ever, occur—mechanism of labour of this kind—signs by which a face presentation may be known—Portal the first to advise that a face presentation should be left to Nature—more children born alive when the face presents than when the nates or feet present—the features of the fœtus in this kind of labour much swollen, but usually recover their natural state in three or four days.

Third order :—those arising from contraction or diminution of the capacity of the channel along which the fœtus has to pass ;—1, undilatable state of the os uteri—always more observed in first labours—two different conditions of the os uteri when it dilates slowly—1, hard, rigid, and heated ;—2, œdematous and soft, compared to an intestine filled with water ;—time generally the best remedy—various opinions

as to the effects of belladonna—in obstinate cases, bleeding the only remedy to be relied upon in the case of rigidity —copious bleeding—first suggested by Dr. Rush—extent to which blood-letting should be carried ;—in the case of soft and œdematous os uteri, bleeding is but of little use ; this state of the os uteri occurs suddenly, usually after the rupture of the membranes, as is supposed, from pressure between the head of the fœtus and the ossa pubis—remarkable case by Duclos—treatment.

3. Contraction of the os uteri from cicatrices—bleeding will sometimes effect its dilatation—necessary occasionally to dilate it with the bistoury—best mode of doing this—the incisions to be made during a pain.

4. Contraction of the vagina and os externum from cicatrices—treatment—copious blood-letting, bougies, if ascertained before labour—incision.

5. Loaded rectum—

6. Or a distended bladder, sometimes impedes labour—treatment.

7. Inflammation and swelling of the soft parts within the pelvis also occasionally impede labour—described by Dr. Hamilton—treatment—reclined position—bleeding.

8. Tumors projecting into the vagina—of various kinds—some have a folicular origin, first pointed out by myself—difficulty of ascertaining whether the tumour be encysted ;—the treatment consists in pushing up the tumour—in puncturing it—in turning—in opening the child's head ;—average success of these various modes of treatment—when solid, question as to opening the head or removing the tumour—Dr. Burn's opinion—Dr. Blundell's opinion—when the tumour is so large that opening the head has been insufficient to effect delivery, question as to the Cesarian section.

9. Diminution of the capacity of the parturient channel in consequence of some deformity, accident, malformation, or disease, of the pelvic bones ;—ample room in the natural state of the pelvis—pelvis small in all its dimensions rarely the cause of fatal obstruction to the passage of the child—most frequent cause of deformity is disease. It is said that a child may be born alive when the conjugate diameter mea-

sures three inches and a half—when it is only three inches the child cannot be born alive—when it is two inches and a half the head must be lessened—when less than an inch and three quarters the Cesarian section may be necessary—Dr. Osborne's case—Dr. Hull's opinion.

INSTRUMENTS—division—into those which have for their object the preservation of the child—and those by which the child is destroyed to lessen its bulk.

FORCEPS—when to be employed—many cases do not admit of a doubt or of delay; and, among others, those of

1. Exhaustion—this often complained of by the patient and her friends when it does not exist—signs by which this state may be ascertained—extremely rare before the rupture of the membranes—very seldom during the first four-and-twenty-hours—symptoms denoting suspension of labour-pains from exhaustion—suspension of labour-pains sometimes occur without exhaustion or danger—treatment.

2. Inflammation of the peritoneum or uterus during labour—symptoms—treatment—bleeding—delivery—saline purgatives.

3. Inflammation of the vagina—produced by the head of the child becoming wedged in the pelvis—this case is called locked head, or impaction—does not occur so frequently as is generally supposed—signs by which it is known—how distinguished from arrest—treatment.

Class of cases in which the forceps become necessary, but in which there are no urgent symptoms requiring their *immediate* application—admit of two opinions as to time—one party advises their application to be delayed as long as pain continues—the other to apply the forceps six hours after an ear can be felt, irrespective of what has been the frequency or force of the uterine action during that period—both the extremes to be avoided. If the head has touched the perineum twelve or thirteen hours with *no advance at all*, the forceps may be applied, although there may be no bad symptoms present; for when the bad consequences of protracted labour, viz. exhaustion or inflammation of the peritoneum or uterus, or inflammation of the vagina, have commenced, they may proceed in spite of delivery.

VECTIS—compared with the forceps—we may sometimes succeed with the vectis where we have been unsuccessful with the forceps, but most frequently the reverse—we rarely succeed with the vectis except there be pain—manner of applying the vectis—to be used more as a *hook* than as a *lever*—attempts to extract to be made during pain.

PERFORATOR—Fœtal brain will bear greater pressure before birth than after the commencement of respiration—but the compression of the fœtal head, so that its short diameter measures less than three inches, is incompatible with life; consequently, when the conjugate diameter measures less than this, it is not a case for the forceps, but for the perforator—the head will not descend into the pelvis, but remains at the brim, when all the consequences of impeded labour—exhaustion, inflammation of the different structures—supervene. When these states are known to exist, the head must be opened, if we cannot succeed by any other means; but when no dangerous symptom is present it is right to wait—a case is related in which the head was small, and became so moulded by the forcible and repeated action of the uterus, that the child was born alive, though the conjugate diameter measured less than three inches—Smellie's case. If the distortion has proceeded from rickets, there is more inducement to wait than when it has been caused by mollites ossium, especially if the woman has previously borne a living child. In the absence of dangerous symptoms, and the action of the uterus has been frequent and powerful for eighteen or twenty hours *after* the complete dilatation of the os uteri, the head during this time making *no* advancement, but still remaining at the brim, there is so little probability of a living child being born, that we are justified in perforating the skull, if we cannot succeed with the vectis or long forceps, and the delay is produced by distorted pelvis.

Mode of performing the operation—situation of the patient—Denman's perforator—to be passed into a suture if possible—the brain to be thoroughly broken down, especially its base;—unless there be then symptoms threatening danger to the mother, better to delay the extraction for some time—

this has often been effected by the fingers, but sometimes necessary to use the CROTCHET or CRANIOTOMY FORCEPS. Sometimes necessary to remove the bones of the skull, all but the base—various opinions as to the smallest measurement of the brim through which the base of the fœtal skull can be extracted—that of Drs. Burns, Hull, Conquest, &c.

Methods proposed with a view of preventing the necessity of destroying the fœtus—1, that of diminishing the quantity of circulating fluids in the mother's system, with the view of limiting the growth of the child, unsuccessful ; —2, Operation of inducing premature labour—first performed by Dr. Hamilton—the average success of this operation—the degree of distortion of the pelvis in which this operation offers most advantages—the period of pregnancy at which it should be done—different modes of bringing on premature labour—1, by separating a portion of the membranes ;—2, by puncturing them—modes of operation. Symptoms which are erroneously said to indicate the death of the child—they probably depend on the previous state of health of the mother ;—to prevent them it is necessary to attend to the condition of the stomach and bowels before the operation.

Sometimes the pelvis is so much contracted that the opening and reducing the bulk of the child's head is insufficient, and it becomes necessary to have recourse to the Cesarian section—this said to be first performed by a German sow-gelder, successfully, upon his own wife—necessary when the pelvis is less in its conjugate diameter than an inch and three quarters—average successful cases in this and other countries—why it has been more successful on the Continent than in England—mode of performing the operation.

CLASS III. OF PRETERNATURAL LABOURS.

Great variety of presentations described by some authors —comparatively few met with in practice—division of this Class into two Orders—1, those in which turning is unnecessary ;—2, those in which turning is required—neces-

sary to be present when the membranes break, especially if the presenting part cannot be ascertained before.

First Order—The presentations of the breech and feet—signs by which the former may be ascertained—an occasional position of the feet, relative to the breech, in which the heel has often been mistaken for the elbow, not described by authors—breech presentations of two kinds—1, that in which the abdomen of the child is situated more or less towards the abdomen of the mother;—2, that in which it is situated more or less towards the back—description of each—treatment of each—1, delay the rupture of the membranes as long as possible;—2, do not convert a breech presentation into one of the feet;—Dr. William Hunter's opinion—3, support the perineum during the expulsion of the breech;—4, leave the expulsion of the child as far as the umbilicus to Nature;—5,—mode of managing the labour after this—various opinions as to the propriety of bringing down the arms—less risk of losing the child in the cases in which the breech, than in those in which the feet are expelled first—method of expediting the expulsion of the breech when required—1, by means of the fingers applied in the groins;—2, by the fillet; 3, by the blunt hook—treatment when a breech case is connected with a narrow pelvis—sometimes necessary to apply the forceps to extract the head, when the body is already expelled — Smellie, the first to have proposed the forceps under these circumstances—head sometimes separated from the body, and left in the uterus—how to extract it.

2. Presentation of one or both feet—by what signs distinguished—treatment.

Second Order—Arm or shoulder presentations—Ambrose Paré first to turn in these presentations—his practice improved upon by La Motte—how to distinguish a presentation of the arm—three kinds of cases:—

1. When the os uteri is dilated to the size of a crown-piece, or fully dilated, with membranes unruptured;
2. When the os uteri is undilated, but the membranes are ruptured;

3. When not only the membranes are ruptured, but the uterus is firmly contracted round the body of the fœtus, and still acting violently.

Rules for the treatment of each.

Turning—position of the patient—various opinions as to the part at which the membranes should be ruptured when the hand is introduced—how to know the situation of the feet, and consequently which hand to use—management of the case when the feet are brought into the vagina.

Treatment of the worst forms of arm presentations—opium—bleeding—warm bath.

Spontaneous expulsion of the fœtus—first observed in this country by Dr. Denman—various opinions as to the manner in which it takes place—signs by which we are led to expect its occurrence.

Cases in which turning is impossible, and spontaneous expulsion does not occur—treatment—blood-letting to syncope—extraction of the child by instruments—two operations:

1. Separation of the head;
2. Removal of the viscera;

Mode of performing each.

Funis presentation—child does not lie with its long axis in the direction of the short axis of the uterus—manner of distinguishing these cases—important to ascertain whether the child be living or dead—proceed upon common principles if it be dead—modes of treatment under various circumstances, when it is living—turning—putting back the funis and retaining it there—various modes of doing this—application of the forceps.

CLASS IV.—OR COMPLICATED LABOURS.

We must be guided in the treatment entirely by the nature of the complication—no cases in which the life of the patient so much depends upon prompt discrimination and treatment as some of these.

PUERPERAL CONVULSIONS—division into various kinds —discrepancy of opinion as to successful treatment explained —occur more frequently in first labours than in subsequent ones—the reverse with regard to hemorrhagy—they may occur before, during, or after labour—premonitory symptoms —symptoms of the attack—how distinguished from hysteria —convulsions from loss of blood.

Convulsions not always succeeded by labour when the attack occurs in the latter period of pregnancy—the two opposite constitutions are equally liable to convulsions;—weakness and irritability, as well as strength and plethora, are strong predisposing causes—exciting causes, labour, constipation, and fulness of the bladder—varied appearances found after death—we are more likely to derive our information as to the nature of convulsions from physiology than from morbid anatomy—a short account of Dr. Marshall Hall's discovery in the nervous system—puerperal convulsions compared with that kind of epilepsy which Dr. Hall has called excentric or centripetal—treatment, to empty the blood-vessels, the bowels, and the bladder—propriety of delivery, and when to deliver — prognosis, if seen early and treated actively, generally favorable—child frequently still-born.

HEMORRHAGY BEFORE THE BIRTH OF THE CHILD—divided into two kinds, dependant upon the situation of the placenta—1, when the placenta is attached over the os uteri, it is called *unavoidable* hemorrhagy;—2, when attached to any other part of the uterus, *accidental* hemorrhagy.

Portal noticed the placenta attached over the os uteri, but it was more accurately described by Levret in France, and afterwards made known in England by Dr. Rigby—hemorrhagy must necessarily occur when labour comes on, when the placenta is thus attached—causes—signs which indicate this attachment of the placenta — often in these cases necessary to introduce the hand into the vagina, properly to examine the os uteri—circumstances determining the quantity of blood lost in a given time—1, extent of surface detached;—2, degree of relaxation of the uterus;—3, period of gestation:—and 4, state of the circulation—in some rare cases the blood has been retained in the uterus

—signs by which the placenta is known to be attached to any other part of the uterus — mode by which Nature checks hemorrhagy from the uterine vessels, compared with that from other parts — general principles of treatment — 1, where the system has not already suffered much, or where the hemorrhagy is not violent;—2, when the contrary—necessary to lessen the bulk of the contents of the uterus, or empty it — when the placenta is not attached over the os uteri, by rupturing the membranes, and where it is, by delivery—bleeding *rarely* employed in cases of hemorrhagy of the latter months of pregnancy; *never*, when the placenta is attaced over the os uteri—mode of rupturing the membranes—delivery to be completed should the child be situated with its long axis in a direction contrary to that of the uterus — mode of delivery when the placenta is situated over the os uteri — various opinions as to delivery when the placenta is only partially situated over the os uteri —period for delivery—not to use force when the parts are rigid—not to wait for *pains*—not to wait for the *dilatation of the os uteri*, but deliver when it is *dilatable;*—generally make use of the left hand—various opinions as to perforating the placenta, or passing the hand by it—reasons for adopting the latter mode; *tampon*—useful when necessary to wait for the dilatability of the soft parts. It is sometimes necessary to wait when the hemorrhagy has ceased, to give time for the patient's strength to recruit before commencing the operation.

If the patient be already dead, the fœtus to be extracted, if possible, through the natural passages; but the child is so seldom alive in cases of hemorrhagy, that the Cesarian section is scarcely admissible.

Ruptured Uterus—of much more frequent occurrence than is generally supposed—rare before the rupture of the membranes—cases are on record where this circumstance has occurred before the completion of pregnancy—causes—1, accidental injuries;—2, deviations from the natural structure of the impregnated uterus; — 3, impediments to the passage of the child out of its cavity. When from mechanical violence, the laceration may assume any direction—when from

other causes, it is usually transverse and opposite the projecting part of the sacrum or linea ilio-pectinea—appearances on dissection—signs by which it is said we may anticipate this circumstance—preventive treatment—sacrifice of the child from such conjecture unjustifiable—signs indicating the accident to have already taken place—vomiting of matter like coffee-grounds, as stated by authors, *very rare*—escape of the child into the abdomen, by no means so frequent as is generally supposed—various opinions as to the propriety of extracting the child or leaving the case to Nature—opinions of Hunter, Denman, Sims, and Dewees. Treatment of ruptured uterus—where the child has escaped into the abdomen and cannot be drawn into the natural passages—is the operation of gastrotomy to be performed?—arguments for and against it. Treatment to be adopted when the child is extracted—causes of death—impropriety of treating all cases alike—useless and dangerous practice of bleeding in anticipation of inflammation.

Twins, Triplets, &c.—Calculations to determine the average number of plural births—presence of a second child cannot be determined till after the birth of the first—signs by which the presence of a second child may be then known. Whether one or more children be in the uterus does not influence our treatment as regards the birth of the first child. Management as regards the birth of the second child—management of the placentæ in twin cases.

Inversion of the Uterus—readily occurs when the uterus is uncontracted after the birth of the child—various degrees of inversion—signs by which inversion of the uterus may be known to have taken place; sometimes the placenta is still attached to the inverted uterus—treatment. Where attempts have been unsuccessful to return the uterus, advisable to bleed to syncope, and endeavour to reduce it during that state. Question as to the propriety of separating the placenta before or after the uterus is returned. Chronic inversion—how distinguished from polypus—treatment.

DISEASES PECULIAR TO WOMEN.

These are divided into those which occur independently of pregnancy, those which take place during gestation, and those which come on after parturition.

DELAYED MENSTRUATION—divided into two kinds—1, suppression;—2, retention—usual period at which the catamenia appear in this country—the first appearance of the catamenia preceded by certain mental and physical changes—causes of delayed menstruation—1, absence or imperfect development of the internal sexual organs;—2, disease of these organs;—3, diseases of remote organs;—4, morbid condition of the general health—divided into acute and chronic, or chlorosis—symptoms of the acute form—bowels often become obstinately confined some months previous to the first appearance of the catamenia, and again resume their regular action when this process is established—treatment. Chlorosis—symptoms similar to those produced by loss of blood—appearances after death—internal œdema—treatment. The disordered condition of the constitution interrupts the function of the uterus, and not the reverse. *Retention* of the catamenia—causes—symptoms—has been mistaken for pregnancy—treatment—the operation of the division of the hymen not unfrequently followed by peritonitis.

The catamenia may have been established, and the function regularly performed for some time, when, from some cause, this function may be checked, constituting what has been called obstructed menstruation—preceded often by the peculiar state of health attendant on delayed menstruation, and, like it, divided into the acute and chronic forms—symptoms—treatment—most frequent causes of suppression—cause may be applied during the continuance of the discharge—when occurring in the robust—symptoms of inflammation and of plethora—when it takes place in the weak and irritable, the symptoms are then usually spasmodic—treatment of the former—of the latter.

DYSMENORRHŒA, or painful menstruation—supposed causes—frequently follows marriage, especially where fa-

tigue, as from travelling, receiving a great deal of company, &c. has been added—this form of dysmenorrhœa often the unsuspected cause of sterility—symptoms of this peculiar form of dysmenorrhœa—treatment—description of the ordinary form of dysmenorrhœa—attended by the discharge of membranous shreds, or a hollow membrane—how this is distinguished from the membranes of an aborted ovum—importance of a correct knowledge of this subject—women not always barren who have expelled this membrane—Morgagni's case—treatment of dysmenorrhœa.

MENORRHAGIA — the word differently applied by different authors—great variety in the quantity of discharge at each catamenial period in different persons—excess to be regarded and treated as disease chiefly when it produces some morbid effect upon the system—division of menorrhagia into active and passive forms—coloured discharges from the uterus often connected with disease of this organ—examination necessary—necessity of repetition of the examination if the cause be not ascertained at first—treatment, when arising from disease, to be regulated according to its nature—treatment of idiopathic menorrhagia in the active form—in the passive form—necessary to restrain the discharge and attend to the general health—mercury said to be beneficial in some obstinate cases.

LEUCORRHŒA, or Fluor Albus—discharge may vary in consistence, quantity, odour, and colour—when yellow and opaque, generally dependent upon acute or sub-acute inflammation. Gonorrhœa cannot be distinguished from leucorrhœa by the colour of the discharge—Ricord's opinion—when the discharge is brown and offensive, and long-continued organic disease may be suspected, necessary to make an examination with the finger or speculum—various kinds of the speculum—Recamier's—glass specula—Ricord's—unnecessary to introduce the speculum during acute inflammation—mode of introducing it;—discharge may have its seat—in the Fallopian tubes—the uterus—the cervix uteri—or the vagina—whether in the uterus or vagina—to be distinguished by the speculum—if in the cervix uteri, by the colour of the discharge. Does leucorrhœa cease during the catamenial

period ?—does it tend to cause abortion ?—may have a constitutional or local origin. It occurs often during teething—as a consequence of weakness, scarlatina, or other exanthemata—as an effect of pregnancy, especially in connection with varicose veins—any obstruction offered to the vena porta occasionally produces it—may occur with chlorosis, undue lactation, or the opposite state of the system—local causes—those situated within the vagina, and those in the vacinity, such as ascarides, hemorrhoides, &c.—treatment—to remove the local cause of irritation, and to attend to the general health.

CONGENITAL MALFORMATION of the uterus and its appendages.

INFLAMMATION of the unimpregnated uterus divided into acute and chronic—former rare—symptoms—causes—effects—treatment. Chronic inflammation—constitution but little disturbed—exists often when not suspected—symptoms—white discharge said to indicate inflammation of its cervix—state of the os uteri at an early period of the disease—granulated state at a later period—if neglected, leads to serious disorganization—treatment—local blood-letting to be preferred to general—leeches to the os uteri—recumbent position—counter-irritation—mercury—iodine—sarsaparilla—sea-side.

COMMON ULCERATION of the cervix uteri—when superficial will readily heal—obstinacy of healing when deep, probably owing to the little cellular membrane entering into the structure of this part, or, more probable, owing to its being accompanied with chronic inflammation—the cases related by M. Recamier were probably of this kind, and not cancer—speculum useful, not only in the investigation of these cases, but in the application of remedies—treatment.

MALIGNANT DISEASES—uterus very liable to—more liable to carcinoma than any other organ—period of life at which this most frequently makes its attack—remark on abortion, as connected with carcinoma—Mr. Abernethy's division of carcinoma into carcinoma and ulcerated carcinoma—almost always commencing in the cervix uteri—various opinions as to the causes of this—two classes of cases of carcinoma—1, *of the part*; 2, *in the part*—symptoms of car-

cinoma—state of the os uteri at an early period—morbid anatomy of carcinoma—treatment—to delay the ulcerative stage and to relieve the most distressing symptoms. Ulcerated carcinoma—progress varies in different persons—symptoms — local—constitutional — complications, inflammation of the bladder, rectum, peritoneum—treatment.

Corroding Ulcer—called, by Madame Boivin, ulcerous cancer — symptoms—difference between it and ulcerated carcinoma—equally fatal—period of its attack—treatment.

Cauliflower Excrescence, or Encephalosis — symptoms—treatment.

Fibrous Tumors—various names by which this affection is designated—symptoms, only those produced mechanically—possess but little, if any, sensibility—morbid anatomy—treatment consists in relieving effects produced upon neighbouring organs.

Polypus of the Uterus — symptoms — examination necessary—how distinguished from inversion—when fatal, destroys life by hemorrhagy—treatment—by excision—by ligature—mode of applying a ligature—application of the ligature upon small polypi greatly facilitated by the use of the speculum—after-treatment.

Retroversion of the Uterus — first described in this country by Dr. William Hunter—most frequeutly occurs between the *eleventh* and *fifteenth* week of pregnancy—sometimes this displacement takes place when the uterus is of a certain size *after* labour—symptoms—cause—necessary to examine with the finger—treatment, to empty the bladder and bowels, and to keep them empty ; the former by the catheter, passed three or four times daily—the latter, by injections or castor oil—to guard against or cure inflammation—sometimes necessary to attempt to replace the uterus by gentle manual assistance, should it not be restored by emptying the bladder, &c. If a catheter cannot be introduced, should the bladder be punctured ?

Affections of the Urethra and Bladder—Excrescence of the urethra—first described by Sharpe—more particularly by Sir Charles Clarke—treatment—pain much lessened in its excision by the previous application of nitrate

of silver—inflammation of the urethra—simple—specific—Ricord's opinion—treatment—thickening of the cellular membrane surrounding the urethra—description of—symptoms—most painful, caused by a partial dilatation of the canal in which a few drops of urine lodge—treatment. General remarks on diseases of the female bladder—stone considered in relation to labour—medical treatment—operations for its removal—1, dilatation of the urethra—2, lithotrity. Retention of urine—mode of introducing the catheter.

PROLAPSUS OF THE BLADDER—Description of—often mistaken for prolapsus uteri—how distinguished—treatment.

PROLAPSUS UTERI—of very frequent occurrence, especially among the working classes—called procidentia when it protrudes externally—distinguished into three degrees—the 1st, or slightest degree, said by Madame Boivin to be a cause of sterility — causes of prolapsus uteri — among which may be reckoned ascites — symptoms — 1, constitutional—2, local—examination per vaginam absolutely necessary to determine the nature of the case—mode of examination—situation of the patient;—when external, the presence of the os uteri at the lowest part will distinguish it from other tumors—how distinguished from elongation of the cervix uteri—the tumor generally recedes when the patient reclines—treatment when there is difficulty of reducing it—treatment when incomplete or easily reducible—constitutional—local treatment—reclined position—astringent injections—pessaries—mode of applying them—Dr. Hamilton's mode unsuccessful—Dr. Marshall Hall's operation.

DISEASES WHICH OCCUR DURING PREGNANCY—in the early period of gestation, generally less dangerous than in the latter months—some dependent on nervous irritation—others on increased vascular action. Headache often depends upon disorder of the alimentary canal—when occurring at the early period of gestation, slight, and unattended by increased power and frequency of the pulse, not usually dangerous—treatment in the strong and plethoric, aperients, with the loss of eight or ten ounces of blood;—in the weak and delicate, aperients; and, when the disordered secretions are corrected, mild tonics, such as bitter infusions, &c.

When headache occurs in the latter months of pregnancy, attended with a frequent and strong pulse, with other symptoms which indicate a determination of blood to the head, an appearance of flashes of light before the eyes, dimness of sight, with temporary blindness, convulsions are threatened, and the greatest danger is indicated — treatment — active purging—*copious* blood-letting.

Hysteria, sometimes mania, palpitation, and dyspnœa, occur during pregnancy, as a consequence of nervous irritation—almost always connected with a disordered state of the stomach and bowels—treatment—aperients, sedatives, especially hyoscyamus — antispasmodics — dyspnœa—occasionally attended with violent cough, hot skin, frequent and strong pulse, indicating inflammation — treatment antiphlogistic, especially blood-letting.

VOMITING may be considered disease when excessively violent, or continuing considerably longer than the usual period, or the first half of the duration of pregnancy—has been known to destroy life, either by exhaustion or rupture of the stomach—usually connected with a loaded and confined state of the bowels—treatment—to empty the bowels and keep them in a proper condition—reclined position—attention to diet. When the vomiting continues obstinate, and the patient is of a plethoric constitution, a few leeches applied to the stomach, or bleeding from the arm, may be beneficial. Obstinate vomiting in the latter months of gestation will occasionally not yield to the above plan, but continue till the uterus is emptied by labour—question as to the propriety of inducing premature labour—objections to this—abstinence from food, with opium, has been attended with success when other methods have failed.

CARDIALGIA—treatment—attention to the bowels—antacids—extraordinary case of, related by Dr. Dewees.

SALIVATION—almost always connected with a confined and disordered state of the bowels and acidity of the stomach —has been mistaken for salivation from mercury—treatment.

PUERPERAL FEVER—appears in a sporadic, as well as an epidemic form—much more severe and fatal when it occurs as an epidemic—contagious or infectious nature denied by M. Tonnellé and M. Dugés, but generally admitted in this

country—the opinions of Dr. Gordon, Dr. Gooch, and Dr. Armstrong, in support of its infectious nature—appearances after death—symptoms—the shivering does not always occur—in 88 cases related by Dr. Collins, only 33 began with shivering. The shivering seems to bear no proportion to the severity of the subsequent symptoms; but I have thought it has often been proportionate to the derangement of the alimentary canal. The disease commences usually about the second or third day after labour: if, from ignorance of the case, or any other cause, it is suffered to proceed, it usually terminates fatally about the fifth or sixth day—causes, where it does not arise from specific contagion—great variety of opinions as to its nature—most opposite plans, at different periods, said to have been successful. The disease, at the present day, generally considered to be an inflammatory affection, the acute form of which lasts but a very short period—treatment—bleeding to syncope—to be guided in the repetition of the blood-letting, not by the appearance of the blood, but by the pain and the pulse. Dr. Gordon has remarked, that, whenever he bled his patient *early* and *copiously*, she recovered; but if he saw his patient more than twenty-four hours after the attack, the disease was no longer in the power of art;—local bleeding—purgatives—calomel—large doses of opium, as advised by the late Dr. Armstrong, likely to mask the disease, and mislead as to the necessity of a repetition of the bleeding.

Puerperal Mania may occur during pregnancy, but is most frequent a few days or a few weeks after labour—causes—erroneously attributed to weaning—from the various sources of exhaustion connected with the pregnant or puerperal state—undue lactation—loss of blood—disorder of the chylopoetic organs—shock or fright. Two points of consideration in our prognosis—1, as regards the mind—2, as regards danger to life—a frequent and quick pulse threatens life—when the circulation is more moderate, the state of mind remains more for our consideration—raving madness more dangerous to life—melancholy more likely to continue—the constitution to be considered in our prognosis—Dr. Burn's opinion—calculations of the average number and period of recoveries, in the various asylums, give an erroneous view as

regards private practice—symptoms—how distinguished from phrenitis—treatment—mercury has been found beneficial—copious blood-letting has destroyed life, or rendered the malady permanent.

Phlegmasia Dolens generally occurs about a fortnight or three weeks after labour, sometimes a month, or later—symptoms—description of the swollen limb — phlegmasia dolens is not confined to the puerperal state—men have been affected with this disease—Sir H. Halford's cases—morbid anatomy—treatment.

Inflammation of the Uterus — causes — uterine hemorrhagy has been considered as one of its causes—symptoms—how distinguished from peritonitis—treatment—early and copious blood-letting are the principal means—morbid anatomy.

Ephemera or Weed—most prevalent in those situations where ague prevails—causes—symptoms—to be carefully distinguished from local inflammation—treatment.

Diseases of the Mammæ following Labour—abscess—treatment—sometimes followed by sinuses — Mr. Hey's observations—excoriation of the nipples—treatment.

DISEASES OF CHILDREN.

I think it may be useful to my pupils if I here reprint two papers which I published some time ago in the Edinburg Medical and Surgical Journal, vol. xxxvi, for 1831, p. 385 ; and vol. xxxv, page 82.

On a variety of Uterine Hemorrhagy not hitherto described.

Two kinds of uterine hemorrhagy have hitherto occupied the attention of accoucheurs. The first is obvious to the patient or by-standers from being *external*, the blood flowing upon the bed-clothes ; the second is generally recognized by its effect upon the countenance and on the action of the heart, in the form of syncope. It is then found, on examination,

that the blood flowing from the internal surface of the uterus has been retained by this organ, which is felt distended, and occupying a proportionate space in the hypogastrium. Both these cases, then, are ascertained clearly on examining the condition of the bed-clothes, or the region of the uterus. Both are alike described as attended by the almost entire absence of uterine pain.

The kind of uterine hemorrhagy which I am about to describe, differs from those in the absence of any material external appearance of hemorrhagy or of uterine tumour, and in the presence of uterine pains.

The patient is first seized with severe recurrent uterine pains, each of which produces a *slight* discharge of blood; she is unexpectedly taken with symptoms of the most alarming syncope; there is but little blood upon the sheets; the uterus is scarcely at all distended. On a careful examination, the uterus is found to contain but a small coagulum, and but a small quantity of blood is found externally; but, in the space between the *os uteri* and the *os externum*, that is, in the space formed by the distended vagina, there is a coagulum of blood of the size of a child's head.

It is important that I should insist upon this occurrence of uterine pains, for they are usually considered to denote security from uterine hemorrhagy. Denman observes, "the accession of uterine pain immediately proclaims that the danger is passing or past." They, on the contrary, frequently afford only a distinctive mark of the kind of hemorrhagy I am describing.

Knowing the influence of terms, I would propose to distinguish these different kinds of uterine hemorrhagy thus: the first may be denominated *external*, the second *intra-uterine*, the one I have described, *intra-vaginal*.

Although, then, there be little external appearance of blood,—although there be little distention of the uterus,—although there be severe pains,—still, if there be the appearance of syncope, we are to suspect a dangerous degree of hemorrhagy, and this we shall find to be of the kind which I have described.

The treatment consists in promptly introducing the hand,

thus stimulating the uterus to contraction, and so to arrest the hemorrhagy, if this be proceeding at the time, and to induce the expulsion of the small coagulum contained within its cavity; and then in removing the whole of the coagulum from the vagina. The rest of the treatment consists in administering the usual remedies for alarming syncope, in applying cold to the region of the uterus, &c. and is not peculiar to the particular form of intra-vaginal hemorrhagy. I need not, therefore, enter upon points sufficiently discussed elsewhere.

Of the intra-vaginal hemorrhagy I have seen many cases. Of three of these I have retained notes, which I proceed to transcribe. The case is indeed not of an uncommon kind, but it is certainly undescribed in any of those books on midwifery usually put into the hands of students. This brief account of it cannot, therefore, be without its utility.

Mrs. C.—— had an easy and natural labour, and had been confined about an hour and a half when the midwife sent for me. I was summoned because she had pains after labour, more frequent, and much more severe, than the midwife had been accustomed to witness. These pains continued to come on at intervals of two or three minutes. I was told that there was not more discharge than is usual, but that a little came away at each pain. She was not pale; her pulse was good; in fact, she had no symptoms of having suffered from loss of blood. The uterus was contracted nearly as much as in ordinary cases, and I found, on placing the hand over the abdomen, that there was an effort of the uterus to contract still more at each pain.

I should have suspected at this time any thing rather than that the woman's life would have been brought into danger by hemorrhagy, so slow was the discharge, so strong were the efforts in the uterus to contract, and so unlike was the case to all others which I have ever seen or heard of. She at length grew pale, her pulse became weak, frequent, and almost imperceptible, and she fainted. I passed my hand into the uterus, although it was but little distended, and found a small coagulum. There was, however, a coagulum in the vagina of the magnitude of a child's head, and there was rather more

blood than usual on the bed-clothes. Upon withdrawing my hand, the pains ceased, and the hemorrhagy stopped. Cold vinegar and water were applied to the abdomen; but I now do not think it was necessary, for I believe the hemorrhagy was entirely stopped by removing the very small coagulum from the uterus, and the very large one from the vagina.

Two months after the occurrence of this case, I attended Mrs. F.——. Her labour was not at all protracted, and during it no unusual circumstance took place. She complained, after the placenta had come away, of pain coming on at intervals. She had experienced nothing of the kind in her two former labours at the same period. The pains continued to come on at intervals of a few minutes, and were so distressing that she cried out violently each time. She at length grew pale, and complained of giddiness and faintness; there was a little discharge with each pain. I put my hand upon the abdomen, and found the uterus contracted nearly as much as in ordinary cases. I could not, by feeling this organ through the parietes of the abdomen, at all suspect internal hemorrhagy; and the blood which had been discharged externally, though greater in quantity than usual, was not sufficient to produce any alarm. I suspected this to be a case like the former, and introduced my hand into the uterus. There was in it a coagulum not very large, but one more than four times its size distended the vagina. When these were removed the pains entirely subsided, and with them the slight discharge which had accompanied them.

The faintness continued many hours, as the discharge of blood had amounted to a very considerable quantity.

The third case occurred in a near relative. Mrs.——, after a tolerably easy labour, and twenty minutes after the placenta had come away, was seized with violent pains coming on at intervals of five minutes, and accompanied with a slight discharge of blood, so very trifling, indeed, that it excited in the attendants no particular notice. She, however, at length became pale, and complained of faintness and giddiness. I put my hand upon the abdomen, and felt the uterus not more distended than usual. From the size of this organ I could have no suspicion of internal hemorrhagy. About seven or

eight ounces of blood were poured out externally. Cold wet cloths were applied to the abdomen, but the pain continued, and the faintness increased. I introduced my hand and removed a very small coagulum from the uterus, and one five times the size from the vagina; and just at this time an additional quantity of fluid blood followed my hand. This produced absolute fainting, which continued eight or ten minutes. During the syncope the patient was slightly convulsed, and just after she had recovered became delirious, in which state she continued for eight or ten minutes. In about four hours from the commencement of the discharge, small doses of opium were taken, and a quiet night was passed. She was confined on Saturday evening, and on Sunday morning no complaint was made but of weakness and giddiness if the head was raised; the pulse was not more than 80; and the tongue clean. Monday was passed in the same manner, with the usual lochial discharge, and there was no complaint. She appeared in every other respect as well on the following morning, Tuesday. The pulse was not more than 80; the tongue clean; the skin cool; and there was no pain; there was a secretion in the breasts, and lochial discharge. As the bowels had not acted, it was thought right to give some castor oil. I saw her after it had acted twice, about three o'clock in the afternoon, when she said she was comfortable. In the evening, at nine o'clock, I again saw her; she had had violent shivering, and was very hot; there was beating in the head, and violent pain in the abdomen, with considerable tenderness; her pulse was 120, and her tongue much furred. Upon a slight view of this case, I certainly should have thought it one of peritonitis, and requiring blood-letting; but upon attentively considering its history, and comparing it with some similar cases related by Dr. Marshall Hall, I made up my mind, that, whatever analogy there seemed to be between its spmptoms and those of peritonitis, it was not inflammation. An opiate was given. In the morning, I heard my patient had slept occasionally; the tongue was becoming clean at its edges; the pulse was not more than 90; there was less heat of the skin; and no pain in the abdomen, but the tenderness continued, although in a less degree. A cold lotion was ap-

plied to the head, for there was still throbbing. In the evening my patient was still better, the tongue was cleaner, and there was less throbbing, and less tenderness. A little solid food was allowed, and the next day she appeared in all respects tolerably well. I have given this case much in detail, because it involves more practical points than the one it is intended chiefly to illustrate.

I conclude this communication by the subjoined letter from a friend, whom I had asked whether he had met with cases similar to those which I have detailed.

"*Highgate, May* 18, 1831.—DEAR SIR,—In compliance with your wish, I have sent a short sketch of two cases which have occurred during the last twelve months in my practice. I have to regret not being able to furnish you with more ample details, not having made any particular notes at the time of their occurrence.

"A. D., of a spare habit, about 30 years of age, was delivered by me of her second child, January 29, 1831, after a natural labour of ten hours' duration. The placenta was detached half an hour afterwards, during the contraction of the uterus. Having administered an opiate, I left her shortly after, going on well,—the uterus contracted, the pulse steady, and not more discharge than usual. I was, however, hastily summoned in two hours, and on my arrival found her in a very weak state, with a pale and anxious countenance, low pulse, and great restlessness, complaining of much pain in the lower part of the abdomen, with a sensation of weight; in fact, she had the symptoms which indicate great loss of blood. On examining the abdomen, the uterus was well contracted; but, on passing the hand into the vagina, (which was done very easily), I found it considerably distended with clots of blood, which I instantly removed. The *os uteri* was nearly closed. The removal of the coagula produced immediate relief, the pain ceased, and having given her some brandy, and, as soon as it could be procured, beef-tea at short intervals, she rallied greatly before I left her. On looking over the clothes and napkins which received the discharges during and after labour, I discovered that there had been very little discharge externally. The clots, on being placed together, were about the size of a child's head at the time of birth.

" The second case presented very little variety from the first, excepting that I was called to the patient five hours after delivery. The uterus was contracted as in the former case. The same treatment was adopted with similar benefit. The woman, however, was not so debilitated, being of a more robust habit. Both cases have done extremely well.—Yours sincerely,

" N. T. WETHERELL."

This kind of hemorrhagy has been since noticed by M. Velpeau—" La troisième (perte interne), qui n'a encore fixé l'attention que d'un petit nombre de praticiens, quoiqu'elle ne soit pas très rare, est caractérisée par la rétention et l'accumulation du sang dans la vagin. M. Heming en cite trois exemples, et M. Wetherell en a recueilli deux autres. Je l'ai observée moi-même deux fois ; et M. Pezerat a publié un fait qui me semble également s'y rapporter ; mais il est rare qu'elle tarde beaucoup à devenir externe. Quoique possible pendant le travail ou la grossesse, c'est cependant après l'accouchement qu'on la rencontre le plus souvent."*

On the Follicular Origin of some Vaginal Tumours which are apt to obstruct Parturition.

Sir Astley Cooper has, in a very interesting paper, described the origin of some encysted tumours to be an enlargement of cuticular follicles ; and, in the second volume of his work upon hernia, that gentleman has described a similar tumour originating in an enlargement of a mucous follicle situated just beneath the meatus.

It has not, I believe, been hitherto conjectured that some of those tumours which are known sometimes to occupy the pelvis and obstruct parturition, have a similar origin. This fact appears, however, to be distinctly established by cases which have fallen under my observation ; and it is the more

* Traité complet de l'Art des Accouchemens, p. 311.

important because it immediately suggests the propriety of the treatment by free incision.

I have carefully examined the bodies of two women in whom I found tumours of this description projecting into the vagina. In one, there were two of these tumours; in the other, there was a single one as large as an egg. On a minute examination of their internal structure, it was evident that they consisted of obstructed lacunæ, which had thereby become dilated into a cyst and distended by a gelatinous fluid. I was enabled to trace distinctly, in the smaller tumour, a continuation of the mucous membrane of the vagina into the tumour, and a reflection of this membrane forming the lining to the latter.

I can have no doubt the tumour in Mrs. H. which I am about to detail was of the same nature. Mr. Vincent, as well as myself, was convinced of this fact; and it is probable that the greater number of those tumours obstructing parturition, which have been described by the authors who have written on this subject, were of similar origin. If this is the case, I think no one would doubt that, when they existed in labour, so as to obstruct the descent of the child, the best practice is to evacuate and thereby diminish them by a very free opening. This view of the case is further confirmed, if that were necessary, by the history of the cases of this kind which are recorded. Perfect, Denman, Park, Merriman, Davis, and Drew, have each described cases in which tumours were found between the vagina and the rectum at the commencement of labour, which, from their bulk, offered greater or less impediment to the passage of the child. Some of the tumours were proved, by examination after death, to have been diseased ovaries; others were concluded to have been ovaries, although all sufficient proof of this fact was wanting; but, in others, the histories of the cases shew that they could not have been ovaries; but they leave the nature of the tumour in complete obscurity.

Some which were not opened disappeared spontaneously after delivery, leaving the practitioner to conjecture what they could have been. Others were opened through the vagina or through the rectum, discharged a bloody serum

with membranous flakes, and became thereby collapsed. Others, during an attempt to lift them above the brim of the pelvis, disappeared, with a sensation of bursting ; and one, an account of which is given by Dr. Drew in the first volume of the Edinburgh Medical and Surgical Journal, was extirpated by an incision in the perinæum.

In this doubtful state of our knowledge concerning the nature of tumours which are not of unfrequent occurrence, which, when they do occur, occasion so material an impediment in the process of parturition, and about the nature and treatment of which the minds of practitioners are so very unsettled, it must be very important to establish the facts of the follicular origin and safe treatment of them by incision.

Besides the proof of the first of these facts already given from dissections, I am enabled to add that of the second by a case which fell under my care some time ago. Mrs. Hollingsworth came to me in April, 1822, with a tumour in the vagina, which a surgeon, whom she had previously consulted, told her was prolapsus uteri. I found an oval tumour situated between the vagina and the rectum : its attachments to either of these parts were so loose that I could, by putting my finger beyond it, hook nearly the whole of it out of the vagina.

It could not be prolapsus ; for the neck of the uterus could be felt above it in its natural situation ; and the same circumstance, together with the absence of the symptoms of pregnancy, proved that it could not be retroversion of the uterus. As the tumour, from its situation and bulk, was very inconvenient, the patient wished to have it removed ; but, before doing it, I advised her to consult another surgeon (Mr. Vincent), who agreed with me in thinking it might be done with safety. I therefore proceeded to perform the operation. On cutting into the tumour, I found that it consisted of a cyst containing a considerable quantity of glairy fluid : this was evacuated, the cyst was left in its situation, and the patient was well in a few days. Three months elapsed, at the end of which time the patient came to me again, stating that the tumour had returned ; that it was considerably larger than the first time she applied to me ; and